HEALTH INSURANCE PREMIUM PAYMENT (HIPP)
Application Form

Name of Applicant/Recipient	Medicaid ID Number
Applicant/Recipient Address	Social Security Number
City, State, Zip	Area Code/Phone Number
Name and Address of Insurance Carrier	Policyholder's Name
	Policy Number
	Policyholder's Social Security Number
	Premium Amount/Month

Source of Insurance ☐ Employee Group Plan ☐ Self-employed
☐ COBRA ☐ Medicare Supplement

How are premiums paid? (Check appropriate box.)

☐ **1.** Paid by insured to insurance carrier

☐ **2.** Paid by insured to employer

☐ **3.** Payroll deduction

Type of policy (Check appropriate box.)

☐ Single coverage

☐ Family coverage

Name of Employer: _____

Address of Employer: _____

_____

Employer Telephone Number: _____

This person has been diagnosed as having: _____

This person has been tested positive for (HIV): ☐ YES ☐ NO

If yes, please attach a copy of the most recent laboratory test, if available.

Submit completed form to:
HIPP Coordinator
Third Party Recovery Section
2508 Mail Service Center
Raleigh, NC 27699-2508

(919) 733-6294 or 1-800-662-7030

DMA-2069